TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-16-3733-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $340.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2016 February 24, 2016	CPT Code 99214 Office Visit	$170.22 x 2 = $340.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 22122-CV: The level of E&M code submitted is not supported by documentation.
   - V122-Code description not listed.

Issues

Does the documentation support billing code 99214? Is the requestor entitled to reimbursement?

Findings

According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 99214 based upon reason code "22122-CV: The level of E&M code submitted is not supported by documentation."

The requestor argues that reimbursement is due based upon "All other claims have been paid at 100%. Therefore, these claims should be paid in full."

28 Texas Administrative Code §134.203(a)(5) states:

> Medicare payment policies when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical reports do not support the documentation requirement which requires 2 of the 3 key components for code 99214, specifically, a detailed history and examination; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/3/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.